



# Member PCP Change Request Form

Please fax to Member's Health Plan

Select one health plan below. Use a separate form for more than one health plan being selected.



Fax 1-844-305-8372



Fax 1-888-999-0649



Fax 1-813-675-2938

MEMBER #1 INFORMATION					
First Name		Last Name		Middle Initial	
Mailing Address				Phone #	
City			State		Zip
Date of Birth			Member ID #		
PCP Name				PCP ID # (Optional)	
PCP Address				PCP Phone #	
PCP City			PCP State		PCP Zip
Reason for PCP Change:	<input type="checkbox"/> Already patient with PCP		<input type="checkbox"/> Network Access		
<input type="checkbox"/> Other:	<input type="checkbox"/> Provider Left Network		<input type="checkbox"/> Quality of Care Concerns		

Additional PCP change requests can be made below to a maximum of 3 requests per form for one plan.

Address for below member is same as above:

MEMBER #2 INFORMATION					
First Name		Last Name		Middle Initial	
Mailing Address				Phone #	
City			State		Zip
Date of Birth			Member ID #		
PCP Name				PCP ID # (Optional)	
PCP Address				PCP Phone #	
PCP City			PCP State		PCP Zip
Reason for PCP Change:	<input type="checkbox"/> Already patient with PCP		<input type="checkbox"/> Network Access		
<input type="checkbox"/> Other:	<input type="checkbox"/> Provider Left Network		<input type="checkbox"/> Quality of Care Concerns		

Address for below member is same as above:

MEMBER #3 INFORMATION					
First Name		Last Name		Middle Initial	
Mailing Address				Phone #	
City			State		Zip
Date of Birth			Member ID #		
PCP Name				PCP ID # (Optional)	
PCP Address				PCP Phone #	
PCP City			PCP State		PCP Zip
Reason for PCP Change:	<input type="checkbox"/> Already patient with PCP		<input type="checkbox"/> Network Access		
<input type="checkbox"/> Other:	<input type="checkbox"/> Provider Left Network		<input type="checkbox"/> Quality of Care Concerns		

Member agrees and willingly selects new PCP:

Print Name of Member or Responsible Party: \_\_\_\_\_

Signature of Member or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Staff Assisting Member: \_\_\_\_\_ Provider Staff Phone: \_\_\_\_\_